Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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MIDWIFERY ADVISORY COUNCIL

April 17, 2007

Medical Board of California
Greg Gorges Conference Room
1424 Howe Avenue
Sacramento, CA 95825
(916) 263-2382

MEMBERS OF THE COUNCIL

Faith Gibson, L.M., Chair
Ruth Haskins, M.D., Vice Chair
Karen Ehrlich, L.M.
Carrie Sparrevohn, L.M.
Guillermo Valenzuela, M.D.
Barbara Yaroslavsky

Action may be taken on any item listed on the agenda.

AGENDA

11:00 a.m.

Members of the Board who are not members of the Council may be attending the meeting as observers.

1. Call to Order/Roll Call
2. Midwife Annual Report Coding System (Business and Profession Code § 2516)
3. Schedule of Future Meetings
4. Public Comment on Items not on the Agenda
5. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Billie Baldo at (916) 263-2365 or sending a written request to Ms. Baldo at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

Meetings of the Midwifery Advisory Council are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Council, but the Chair may apportion available time among those who wish to speak.
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For additional information, contact the Licensing Program at (916) 263-2382.

March 30th, 2007

Worksheet for the Midwifery Council

Development of codes for categories of 'Reasons & Complications' for transfer

Compiled by Faith Gibson, LM, Chair, MAC

The following is a comprehensive list compiled from the four sources included in the Council's info packet @ the 03-09-07 meeting (i.e., Medical Board version, plus MANA, Understanding Birth Better and the California Midwifery Standard of Care). Dr Haskins, Vice-chair of the Council, also forwarded the Mercy Hospital of Folsom guidelines for consultation or transfer of maternity patients by family practice physicians for our consideration. That material is appended to the end of the document.

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Background Information & Instructions

For at least the first year, we will most likely be using a paper reporting system. SB 1638 actually requires the MBC to develop a printable paper document for LMs to use. The development of the codes for that document is what we will be addressing at the April 17th Council meeting.

Please read and note any additions or deletions or other ideas that you want to recommend at the public meeting of the Midwifery Council in April. Nothing here is written in stone – they are only possibilities. All decisions to include, exclude or add new material will be determined during the public meeting of the Council.

These lists are ***not*** *a standard of care* document. They are merely a menu of different reasons why a client who initially planned a home birth under a LM's care had to be transferred to a medical service provider or a hospital, the maternal-infant outcomes for those transferred and the identified reason or diagnosis associated with any maternal or infant death.

These reasons include non-medical circumstances as well as a host of medical complications. While these categories can't be exhaustive, there is also no benefit in having such short lists that midwives can't find a suitable category, are confused or have a hard time carrying out their legal obligations.

One hopes that the final work product will be reduced in length and complexity. Our the bottom line is the need to produce a form that accurately collects the items of information required by SB 1638, while still being as midwife-friendly as we can possibly design.

I look forward to seeing many mothers, midwives and interested citizens on the 17th.

Faith Gibson, LM #041

Worksheet – Please bring with you to the Council meeting on April 17th.

For your information, all *statistical reporting aspects* have been summarized from SB 1638, starting with 2516 (a) **(#3)** (Red text = out of ordered from authorizing statute to maintain a logical flow for each category, i.e., keep antepartum elective and urgent transfer contiguous to one another, etc)

(A) **Total # clients served as primary midwife at onset of care**

(B) # _____ clients served with **collaborative** care thru or by an MD

(C) # _____ clients served **under supervision** of an MD

(D) # ____ **of live birth** attended as primary midwife in each **county**

(E) # _____**of fetal demise** attended as primary MF at discovery of demise in each **county**

(J) # _____ of PHB at onset of labor and after first assessment by the midwife and # ____ of completed PHBs (i.e. no transport up to 6 hrs after birth

(K) # of completed PHBs that included any of the following:

(i) twins

(ii) higher order multiple gestation (beyond twins)

(iii) VBAC

(iv) breech

(F) # ____ (elective) **transfers** to health care practitioner during **pregnancy**

1.Reason for each transfer **LIST #1**

(H) # **urgent/emergency transfers** during **antepartum** total #_____

1. Reasons for each **LIST #2 – A** **Mother**

LIST #2 - B **Fetus**

2. Outcome for each **LIST #3 - A** **Maternal**

LIST#3 - B **Baby**

(G) # **elective transferred** during intrapartum total # ____

1. Reasons for each **LIST #4 -A** **Maternal / Labor**

LIST #4 -B **Fetus / Intrapartum**

2. Outcome for each **LIST #5 -A** **Maternal**

LIST #5 - B **Baby**

(I) # _____ of **urgent/emergency transports** of Mother or Baby during **intrapartum** or **immediate postpartum** (<6hrs)

1. Reason / complications for transfer of each

(a) Mother / Fetus **LIST #6 A - Maternal Intrapartum**

LIST #7 A - Fetal / Intrapartum

(b) Mother / Baby **LIST #6 B - Maternal Postpartum**

LIST #7 B - Neonatal / Immediate Postpartum

2. **Outcome** for each

(a) Mother **LIST #8 A - Mother**

(b) Baby **LIST #9 A - Baby**

(L) A brief description of any complication resulting in the mortality of

1. Mother **LIST #10 -A**

2. Infant **LIST #10 -B**

I. LISTS of Outcome Codes

(F) # transfers to health care practitioner during **pregnancy** (1) reason for each transfer **LIST #1**
Maternal 1. Chronic non-pregnancy medical conditions (heart disease, TB, cancer, etc)

2. Non-pregnancy mental health problems, incl. eating disorders, PTSD, etc

3. Pregnancy-induced hypertension // toxemia-pre-eclampsia

4. HELLP

5. Blood coagulation disorders (Factor 5 Liden, etc); embolism, phlebitis

6. Persistent / pernicious anemia, maternal failure to gain weight

7. Vaginal bleeding, suspected placental implantation abnormalities

8. Miscarriage or termination due to maternal/fetal factors - specify _____

8. Clinical judgment of MF

9. Other _____

Fetal

1. Intra-uterine growth restriction, oligo or polyhydramnios

2. Fetal heart irregularities /distress

3. Serious fetal abnormalities or conditions revealed by ultrasound exams

4. PPROM

5. Pre-term labor

6. Unstable fetal lie, other position incompatible with vaginal birth

7. Other _____

(H) # **urgent/emergency transfers** during **antepartum** total _____

1. Reasons for each **(LIST #2 -A)**

(a) **Mother**: Acute medical conditions, inc but not limited to: toxemia -pre-eclampsia, HELLP, bleeding, embolism, stroke, seizures, PTL

(b) Fetus: **(LIST #2 -B)** Cord or placental accidents, fetal heart rate irregularities/distress, fetal demise

2. **Outcome for each**

Maternal Status: **(LIST #3-A)**

1. NSVD

2.Episiotomy

3. Instrumental delivery (forceps, vacuum extraction)

4. Cesarean

5. Serious medical complications including but not limited to: ICU admission, emergency hysterectomy, CVA,

6. Maternal death

Baby – number in each category: (LIST #3-B)

1. Live birth

2. Fetal demise diagnosed prior to labor

3. Stillbirth @ del (no heartbeat, no respiratory effort, no movement)

4. Neonatal death @ < 1 hr; __ < 6 hrs __< 24 hrs __ day 2 > 45 __

5. NICU beyond 10 days

a. Diagnosis _____

6. **Neonatal birth defects**

a. minor _____

b. major _____

c. lethal _____

(G) # elective transfers during intrapartum total _____

1. Reasons for each

Maternal / labor management issues: **(LIST #4 -A)**

1. General maternal request for medical care

2. Prolonged rupture of membranes without onset of active labor

3. Prolonged period of non progressive labor pattern

4. Required / requested medical methods of pain relief

5. Abnormal maternal vital signs -- elevated BP or febrile (>>100.4 F)

6. Pernicious vomiting / dehydration / exhaustion

7. Inadequate progress despite active labor pattern

8. Vaginal bleeding and/or abnormal pain indicating uterine or placental abnormalities

9. Clinical judgment of midwife based on cluster of minor variations /deviations or unusual circumstances

10. Other _____

Fetal / intrapartum (LIST #4 -B)

1. Unstable lie or fetal position incompatible with vaginal delivery

2. Prolonged period of non-reassuring fetal heart tone pattern unresponsive to normal corrective measures

3. Sustained fetal distress, including but not limited to prolonged bradycardia, tachycardia or ominous decelerations, other S/S

4. Thick meconium when birth is not imminent

5. Cord prolapse

6. Shoulder dystocia

7. Other _____

2. Outcome for each

Maternal (LIST #5 A)

1. NSVD

2. Assisted vaginal birth (episiotomy)

3. Instrumental delivery (forceps, vacuum extraction)

4. Cesarean

5. Serious medical complications including but not limited to:
ICU admission, emergency hysterectomy, CVA

6. Maternal death

Baby – number in each category: (LIST #5 -B)

1. Clinical judgment of midwife

   a. @ time of delivery

   b. first hour

   c. under 6 hrs

   d. under 24 hrs

   e. day 2 >> day 45

2. Live birth

3. Fetal demise diagnosed. prior to labor

4. Stillbirth @ del (no heartbeat, no respiratory effort, no movement)

5. Neonatal death @ < 1 hr; __ < 6 hrs __< 24 hrs __ day 2 > 45 __

6. NICU beyond 10 days

   a. diagnosis _____

7. **Neonatal birth defects**

   a. minor _____

b. major _____

c. lethal _____

(I) # of **urgent transfer or /emergency** transports of mother or baby during **intrapartum** or **immediate postpartum** (<6hrs)

1. Reason/complications for transport of mother

Maternal / labor management issues: **(LIST #6 -A)**

1. Abnormal maternal vital signs -- elevated BP or febrile (>>100.4 F)

2. Seizure or loss of consciousness (beyond brief syncope)

3. Vaginal bleeding and/or abnormal pain indicating uterine or placental abnormalities

4. Labor-related problems as identified by the midwife

5. Clinical judgment of midwife

6. Other _____

Fetal / intrapartum (LIST #7 A)

1. Unstable lie or fetal position incompatible with vaginal delivery

2. Non-reassuring fetal heart tone pattern unresponsive to normal corrective measures

3. Sustained fetal distress, including but not limited to prolonged bradycardia, tachycardia, ominous decelerations, or other S/S

4. Thick meconium when birth is not imminent

5. Cord prolapse

6. Shoulder dystocia

7. Other _____

Maternal / postpartum issues **(LIST #6 -B)**

1. Maternal hemorrhage

2. Uterine prolapse, inversion or rupture

3. Retained placenta requiring medical services

4. Hypotension /shock

5. Perineal laceration >> midwife's abilities /scope of practice

6. Abnormal vital signs -- elevated BP or febrile (>>100.4 F)

7. Clinical judgment of the midwife

8. Other _____

Neonate /immediate postpartum (LIST #7 B)

1. Clinical judgment of midwife

    a. @ time of delivery

    b. first hour

    c. under 6 hrs

    d. over 24 hrs

2. Prolonged resuscitation (not counting *less than 6 assisted breaths* per protocols to inflate lungs for slow to pink up babies)

    a. 1-10 m ___ 11-29 m____ >> 30 minutes ____

3. Apgar below 7 at five minutes without progressive improvement by 10 minutes

4. Evident birth defects requiring medical evaluation or treatment

5. Abnormal newborn exam or behaviors – prematurity, IUGR, jaundice, abnormal vital signs (heart rate, respirations, temp) etc

6. Seizures, diminished level of consciousness,

7. Cardiac irregularities, respiratory distress, persistent central cyanosis, persistent poor muscle tone, atonia

8. Other _____

2. **Outcome** for each

(a) **mother** **LIST # 8**

1. NSVD

2. Episiotomy

3. Instrumental delivery (forceps, vacuum extraction)

4. Cesarean

5. Serious medical complications including but not limited to: ICU admission, emergency hysterectomy, CVA

6. Maternal death

(b) **baby** **LIST #9**

1. Hospitalization of neonate

(a) Elective transfer for evaluation/treatment based on clinical judgment of midwife:

a. @ time of delivery

b. first hour

c. under 6 hrs

d. under 24 hrs

(b) Emergency transport // POV or paramedic-EMTs

a. @ time of delivery

b. first hour

c. under 6 hrs

d. under 24 hrs

2. Live birth

3. Fetal demise diagnosed prior to labor

4. Stillbirth @ del (no heartbeat, no respiratory effort, no movement)

5. Neonatal death @ < 1 hr; __ < 6 hrs __< 24 hrs __ day 2 > 45 __

6. NICU beyond 10 days

a. Diagnosis _____

7. **Neonatal birth defects**

a. minor _____

b. major _____

c. lethal _____

(L) A brief description of any complication resulting in the **mortality** of
(regardless of place of birth, which would include AP/IP/PP/NN hospital transfers but not accidents or homicides)

(1) **Mother** **(LIST #10 -A)**

1. Delayed PP hemorrhage

2. Infection – systemic or perineal wound

3. Hypertension / eclampsia

4. Pulmonary embolism / thrombophlebitis /CVA

5. PP Depression

6. PP psychosis

7. Other _____

(2) **Infant** **(LIST #10 - B)**

1. Congenital anomalies (specify:) _____

2. Non-birth related medical conditions – cardiac, respiratory, metabolic, SIDS

3. Encephalopathy, seizure

5. Respiratory Distress / MAS

6. Signs/symptoms of infection / GBS

7. Birth injury (specify): _____

8. Other _____

Mercy Hospital of Folsom, Ca

GUIDELINES FOR OBSTETRICAL CARE

This document is intended to represent simply *guidelines* for sharing in the care of obstetrical patients who plan their deliveries at the Mercy Hospital of Folsom. It provides recommendations directed to **Family Practice physicians** when maternal risk factors merit consideration for consultation or transfer of the pregnant patient. The purpose of creating this document is to clarify to the physicians, staff and to the patients, in a given set of circumstances, who is the ultimate "decision maker". It is done in order to optimize the quality of care given to our patients, to minimize miscommunications or misunderstandings, and to appropriately share the liability involved in caring for the high risk pregnant patient.

The recommendations are divided into a three by three grid:

Recommendations may come out of events:

1. – based on maternal medical history or prior obstetrical history
2. – based on events that occur during the pregnancy
3. – based on events that occur during labor or the post-partum period.

Recommendations may be to:

1. – consider consulting a specialist
2. – recommend consulting a specialist
3. – recommend transfer of care to a specialist.

These are simply guidelines and do not define standard of care. The consultation may be to an obstetrician, a perinatologist, a cardiologist, a geneticist or some other indicated specialist. The consultation may be a simple telephone discussion (which should be well documented in the patient record) or a face to face medical visit, but should be patient specific, and not a record of a previous generalized discussion with a consultant.

MEDICAL BOARD OF CALIFORNIA

DIVISION OF LICENSING

STANDARD OF CARE FOR CALIFORNIA LICENSED MIDWIVES

September 15, 2005

MIDWIFERY STANDARDS OF CARE

The California licensed midwife is a professional health care practitioner who offers primary care to healthy women and their normal unborn and newborn babies throughout normal pregnancy, labor, birth, postpartum, the neonatal and inter-conceptional periods.

I. PURPOSE, DEFINITIONS & GENERAL PROVISIONS

A. This document provides a framework to identify the professional responsibilities of licensed midwives and permit an individual midwife's practice to be rationally evaluated, to ensure that it is safe, ethical and consistent with the professional practice of licensed midwifery in California. However, this standard of care is not intended to replace the clinical judgment of the licensed midwife.

Sources and documentation used to define and judge professional practice include but are not limited to the following:

1. The international definition of a midwife and the midwifery scope of practice
2. Customary definitions of the midwifery model of care by state and national midwifery organizations, including the Licensed Midwifery Practice Act of 1993 and all it amendments (Business and Professions Code Sections 2505, et seq.)
3. Standards of practice for community midwives as published by state and national midwifery organizations
4. Philosophy of care, code of ethics, and informed consent policies as published by state and national midwifery organizations
5. Educational competencies published by state and national direct-entry midwifery organizations

B. The California licensed midwife shall maintain all requirements of state and, where applicable, national certification, while keeping current with evidence-based and ethical midwifery practice in accordance with:

1. The body of professional knowledge, clinical skills, and clinical judgments described in the **Midwives Alliance of North America** (MANA) Core Competencies for Basic Midwifery Practice
2. The statutory requirements as set forth in the **Licensed Midwifery Practice Act of 1993** ("LMPA"), all amendments to LMPA and the Health and Safety Code on birth registration
3. The generally accepted guidelines for community-based midwifery practice as published by state and national direct-entry midwifery organizations

C. The California licensed midwife provides care in private offices, physician offices, clinics, client homes, maternity homes, birth centers and hospitals. The licensed midwife provides well-women health services and maternity care to essentially healthy women who are experiencing a normal pregnancy. An essentially healthy woman is without serious pre-existing medical or mental conditions affecting major body organs, biological systems or competent mental function. An essentially normal pregnancy is without serious medical complications affecting either mother or fetus.

D. The California licensed midwife provides the necessary supervision, care and advice to women prior to and during pregnancy, labor and the postpartum period, conducts deliveries and cares for the newborn infant during the postnatal period. This includes preventative measures, protocols for variations and deviations from norm, detection of complications in the mother and child, the procurement of medical assistance when necessary and the execution of emergency measures in the absence of medical help.

E. The California licensed midwife's fundamental accountability is to the women in her care. This includes a responsibility to uphold professional standards and avoid compromise based on personal or institutional expediency.

F. The California licensed midwife is also accountable to peers, the regulatory body and to the public for safe, competent, ethical practice. It is the responsibility of the licensed midwife to incorporate ongoing evaluation of her practice, including formal or informal sources of community input. This includes but is not limited to the licensed midwife's participation in the peer review process and any required mortality and morbidity reporting. The results of these individual evaluations can be distributed to influence professional policy development, education, and practice.

G. The California licensed midwife is responsible to the client, the community and the midwifery profession for evidence-based practice. This includes but is not limited to continuing education and on-going evaluation and application of new information and improved practices as recommended in the scientific literature. It may also include developing and dispersing midwifery knowledge and participating in research regarding midwifery outcomes.

H. The California licensed midwife shall use evidence-based policies and practice guidelines for the management of routine care and unusual circumstances by establishing, reviewing, updating, and adhering to individualized practice policies,

guidelines and protocols. This shall be appropriate to the specific setting for a client's labor and birth and geographical characteristics of the licensed midwife's practice. Practice-specific guidelines and protocols are customarily implemented through standard or customized chart forms, informed consent and informed refusal documents and treatment waivers, other formal and informal documents used routinely for each area of clinical practice, including but not limited to the antepartum, intrapartum, postpartum, newborn periods and inter-conceptional period.

I. The licensed midwife's policies, guidelines and protocols shall be consistent with standard midwifery management as described in standard midwifery textbooks or a combination of standard textbooks and references, including research published in peer-review journals. Any textbook or reference which is also an approved textbook or reference for a midwifery educational program or school shall be considered an acceptable textbook or reference for use in developing a midwife's individual policies and practice guidelines. When appropriate or requested, citations of scientific source should be made available for client review.

J. The licensed midwife may expand her skill level beyond the core competencies of her training program by incorporating new procedures into the individual midwife's practice that improve care for women and their families. It is the responsibility of the licensed midwife to:

1. Identify the need for a new procedure by taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensure that there are no institutional, state, federal statutes or regulations that would constrain the midwife from incorporation of the procedure into her practice.
3. Be able to demonstrate knowledge and competency, including:
    a) Knowledge of risks, benefits, and client selection criteria.
    b) Having a process for acquisition of required skills.
    c) Identifying and managing complications
    d) Employing a process to evaluate outcomes and maintain professional competency
4. Identify a mechanism to obtaining medical consultation, collaboration, and referral related to each new procedure.

II. A BRIEF OVERVIEW OF THE LICENSED MIDWIFE'S DUTIES AND SPECIFIC RESPONSIBILITIES TO CHILDBEARING WOMEN AND THEIR UNBORN AND NEWBORN BABIES

A. The California licensed midwife engages in an ongoing process of risk assessment that begins with the initial consultation and continues throughout the provision of care. This includes continuously assessing for normalcy and, if necessary, initiating appropriate interventions including consultation, referral, transfer, first-responder emergency care and/or emergency transport.

B. Within the midwifery model of care, the licensed midwife's duties to mother and baby shall include the following individualized forms of maternity care:

1. Antepartum care and education, preparation for childbirth, breastfeeding and parenthood
2. Risk assessment, risk prevention and risk reduction
3. Identifying and assessing variations and deviations from normal and detection of abnormal conditions and subsequently communicating that information to the childbearing women and, when appropriate, to other health care providers and emergency responders.
4. Maintaining an individual plan for consultation, referral, transfer of care and emergencies
5. Evidence-based physiological management to facilitate spontaneous progress in labor and normal vaginal birth while minimizing the need for medical interventions
6. Procurement of medical assistance when indicated
7. Execution of appropriate emergency measures in the absence of medical help
8. Postpartum care to mother and baby, including counseling and education
9. Maintaining up-to-date knowledge in evidence-based practice and proficiency in life-saving measures by regular review and practice
10. Maintenance of all necessary equipment and supplies, and preparation of documents including educational handouts, charts, informed consent & informed refusal documents and treatment waivers, birth registration forms, newborn screening, practice policies, guidelines, protocols, and, if required by law, morbidity and mortality reports and annual statistics.

III. STANDARDS OF PRACTICE FOR COMMUNITY-BASED MIDWIFERY

STANDARD ONE: The licensed midwife shall be accountable to the client, the midwifery profession and the public for safe, competent, and ethical care.

STANDARD TWO: The licensed midwife shall ensure that no act or omission places the client at unnecessary risk.

STANDARD THREE: The licensed midwife shall, within realistic limits, provide continuity of care to the client throughout the childbearing experience according to the midwifery model of care.

STANDARD FOUR: The licensed midwife shall respect the autonomy of the mentally competent adult woman by working in partnership with her and recognizing individual and shared responsibilities. The midwife recognizes the healthy woman as the primary decision maker throughout the childbearing experience.

STANDARD FIVE: The licensed midwife shall uphold the client's right to make informed choices about the manner and circumstance of normal pregnancy and childbirth and facilitates this process by providing complete, relevant, objective information in a non-authoritarian and supportive manner, while continually assessing safety considerations and risks to the client and informing her of same.

STANDARD SIX: The licensed midwife shall confer and collaborate with other healthcare professionals, including other midwives, as is necessary to professionally meet the client’s needs. When the client's condition or needs exceed the midwife's scope of practice or personal practice guidelines, the licensed midwife shall consult with and refer to a physician or other appropriate healthcare provider.

STANDARD SEVEN: Should the pregnancy become high-risk and primary care be transferred to a physician, the licensed midwife may continue to counsel, support and advise the client at her request.

STANDARD EIGHT: The licensed midwife shall maintain complete and accurate health care records.

STANDARD NINE: The licensed midwife shall ensure confidentiality of information except with the client's consent, or as required to be disclosed by law, or in extraordinary circumstances where the failure to disclose will result in immediate and grave harm to the client, baby or other immediate family members or professional care providers.

STANDARD TEN: Where geographically feasible, the licensed midwife shall make a good faith effort to ensure that a second midwife, or a qualified birth attendant certified in neonatal resuscitation and cardiopulmonary resuscitation, is available during the delivery.

STANDARD ELEVEN: The licensed midwife shall order or administer only those prescription drugs and procedures that are consistent with the licensed midwife’s

professional training, community standards and the provisions of LMPA and shall do so only in accordance with the client's informed consent.

STANDARD TWELVE: The licensed midwife shall order, perform, collect samples for or interpret those screening and diagnostic tests for a woman or newborn which are consistent with the licensed midwife's professional training, community standards, and provisions of the LMPA, and shall do so only in accordance with the client's informed consent.

STANDARD THIRTEEN: The licensed midwife shall participate in the continuing education and evaluation of self, colleagues and the maternity care system.

STANDARD FOURTEEN: The licensed midwife shall critically assess evidence-based research findings for use in practice and shall support research activities.

IV. CRITERIA FOR CLIENT SELECTION

Criteria for initial selection of clients for community-based midwifery care assumes:

- Healthy mother without serious pre-existing medical or mental conditions
- History, physical assessment and laboratory results within limits commonly accepted as normal with no clinically significant evidence of the following:

  a. cardiac disease
  b. pulmonary disease
  c. renal disease
  d. hepatic disease
  e. endocrine disease
  f. neurological disease
  g. malignant disease in an active phase
  h. significant hematological disorders or coagulopathies
  i. essential hypertension (BP >>140/90 on two or more occasions, six hours apart)
  j. insulin-dependent diabetes mellitus
  k. serious congenital abnormalities affecting childbirth
  l. family history of serious genetic disorders or hereditary diseases that may impact on the current pregnancy
  m. adverse obstetrical history that may impact on the current pregnancy
  n. significant pelvic or uterine abnormalities, including tumors, malformations, or invasive uterine surgery that may impact on the current pregnancy
  o. isoimmunization
  p. alcoholism or abuse
  q. drug addiction or abuse
  r. positive HIV status or AIDS
  s. current serious psychiatric illness
  t. social or familiar conditions unsatisfactory for domiciliary birth services
  u. other significant physical abnormality, social or mental functioning that affects pregnancy, parturition and/or the ability to safely care for a newborn
  v. other as defined by the licensed midwife

V. RISK FACTORS IDENTIFIED DURING THE INITIAL INTERVIEW OR ARISING DURING THE COURSE OF CARE

A. Responsibility of the Licensed Midwife

With respect to the care of a client with a significant risk factor as identified by the client selection criteria in section IV or other science-based parameters, the licensed midwife shall inform the client about the known material risks and benefits of continuing with midwifery care relative to the identified risk factor and shall recommend to the client that her situation be evaluated by a medical practitioner and if appropriate, to transfer her primary care to a licensed physician who has current training and practice in obstetrics.

B. Client's Rights to Self-Determination

In recognition of the client's right to refuse that recommendation as well as other risk-reduction measures and medical procedures, the client may, after having been fully informed about the nature of the risk and specific risk-reduction measures available, make a written informed refusal. If the licensed midwife appropriately documents the informed refusal in the client's midwifery records, the licensed midwife may continue to provide midwifery care to the client consistent with evidence-based care as identified in this document and the scientific literature.

VI. ANTEPARTUM REFERRAL

- **To define and clarify minimum practice requirements for the safe care of women and infants in regard to ANTEPARTUM PHYSICIAN CONSULTATION, REFERRAL & TRANSFER OF CARE**

The licensed midwife shall consult with a physician and/or other health care professional whenever there are significant deviations (including abnormal laboratory results), during a client's pregnancy. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes, during the pregnancy and, if possible, being present during the labor and birth and resuming postpartum care if appropriate.

The following conditions, occurring after acceptance for domiciliary care, require physician consultation by the midwife or client referral to a physician and may require transfer of care of the client to medical health care provider. A referral for immediate medical care does not preclude the possibility of a domiciliary labor and birth if, following the referral, the client does not have or no longer has, any of the conditions set out in this section.

Antepartal Conditions include, but are not limited to:

Maternal:

a. positive HIV antibody test
b. threatened or spontaneous abortion after 14 weeks
c. significant vaginal bleeding
d. persistent vomiting with dehydration
e. symptoms of malnutrition or anorexia
f. protracted weight loss or failure to gain weight
g. gestational diabetes, uncontrolled by diet
h. severe anemia, not responsive to treatment
i. severe or persistent headache
j. evidence of pregnancy induced hypertension (PIH) or pre-eclampsia (2 blood pressure readings >> than 140/90, 6 hours apart)
k. deep vein thrombosis (DVT)
l. urinary tract infection (UTI)
m. significant signs or symptoms of infection
n. isoimmunization, positive Rh antibody titer for Rh-negative mother, or any other positive antibody titer which may have a detrimental effect on mother or fetus
o. documented placental anomaly or previa
p. documented low lying placenta in woman with history of previous cesarean
q. preterm labor (before the completion of the 37th week of gestation)
r. premature rupture of membranes (before 37 completed weeks of pregnancy)

s. pregnancy with non-reactive stress test and/or
abnormal biophysical profile or amniotic fluid assessment
t. other as defined by the Midwife

Fetal:

a. lie other than vertex at term
b. multiple gestation
c. fetal anomalies compatible with life which are affected by site of birth
d. marked decrease in fetal movement, abnormal fetal heart tones (FHTs)
non-reassuring non-stress test (NST)
e. marked or severe poly- or oligo-hyramnios (too much or
too little amniotic fluid)
f. evidence of intrauterine growth restriction (IUGR)
g. significant abnormal ultrasound findings
h. other as defined by the licensed midwife

VII. INTRAPARTUM REFERRAL

- **To define and clarify minimum practice requirements for the safe care of women and infants in regard to INTRAPARTUM PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT**

The licensed midwife shall consult with a physician and/or other health care professional whenever there are significant deviations from normal during a client's labor and birth, and/or with her newborn. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes, remaining present throughout the birth and resuming postpartum care if appropriate.

A. The following conditions require physician consultation and may require transfer of care. Consultation does not preclude the possibility of a domiciliary labor and birth if, following the consultation, the client does not have any of the conditions set out in this section.

Intrapartum Conditions ~ Serious medical/obstetrical or perinatal conditions, including but not limited to:

Maternal:

a. prolonged lack of progress in labor
b. abnormal bleeding, with or without abdominal pain; evidence of placental abruption
c. rise in blood pressure above woman's baseline (more than 30/15 points or greater than 140/90) with proteinuria
d. signs or symptoms of maternal infection
e. signs or symptoms of maternal shock
f. client's request for transfer to obstetrical care
g. active genital herpes lesion in labor

Fetus:

a. abnormal fetal heart tones (FHT)
b. signs or symptoms of fetal distress
c. thick meconium or frank bleeding with birth not imminent
d. lie not compatible with spontaneous vaginal delivery or unstable fetal lie

B. **Emergency Transport:** If on initial or subsequent assessment during the 1st, 2nd or 3rd stage of labor, one of the following conditions exists, the licensed midwife shall immediately consult with a physician and/or initiate immediate emergency transfer to medical care. Transport via private vehicle is an acceptable method of

transport if, in the clinical judgment of the licensed midwife, that is the safest and most expedient method to access medical services.

a. prolapsed umbilical cord
b. uncontrolled hemorrhage
c. preeclampsia or eclampsia
d. severe abdominal pain inconsistent with normal labor
e. chorioamnionitis
f. ominous fetal heart rate pattern or other manifestation of fetal distress
g. seizures or unconsciousness in the mother
i. evidence of maternal shock
j. presentation not compatible with spontaneous vaginal delivery
k. laceration requiring repair outside the scope of practice or practice policies of the individual licensed midwife
l. retained placenta or placental fragments
m. neonate with unstable vital signs
n. any other condition or symptom which could threaten the life of the mother, fetus, or neonate as assessed by the licensed midwife exercising ordinary skill and knowledge.

C. Emergency Exemptions Clause – Business and Professions Code Section 2058 – Medical Practice Act

The California licensed midwife may deliver a woman with any of the above complications or conditions, or other bona fide emergencies, if the situation is a verifiable emergency and no physician or other equivalent medical services are available. **EMERGENCY** is defined as a situation that presents an immediate hazard to the health and safety of the client or entails extraordinary and unnecessary human suffering.

VIII. POSTPARTUM REFERRAL

- **To define and clarify minimum practice requirements for the safe care of women and infants in regard to POSTPARTUM PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT**

The licensed midwife shall consult with a physician and/or other health care professional whenever there are significant deviations from normal (including abnormal laboratory results), during the postpartum period. If a referral to a physician is needed, the licensed midwife will remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes.

A. Immediate Postpartum Conditions.

The licensed midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions are present.

a. uterine prolapse or inversion
b. uncontrolled maternal hemorrhage
c. seizure or unconsciousness
d. sustained on-going instability or abnormal vital signs
e. adherent or retained placenta;
f. repair of laceration(s)/episiotomy beyond licensed midwife's level of expertise
g. anaphylaxis
h. other serious medical or mental conditions

B. Extended Postpartum Condition.

The licensed midwife shall arrange for physician consultation, client referral and/or transport when/if:

a. signs or symptoms of maternal infection
b. signs of clinically significant depression
c. social, emotional or other physical conditions as defined by the licensed midwife and outside her scope of practice.

IX. NEONATAL REFERRAL

- **To define and clarify minimum practice requirements for the safe care of women and infants in regard to PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT OF THE NEONATE**

The licensed midwife shall consult with a physician or other health care practitioner whenever there are significant deviations or complications relative to the newborn. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to continue caring for her client to the greatest degree possible, in accordance with the client's wishes, during the postpartum/postnatal period.

The following conditions require physician consultation or client referral and may require transfer of care.

A. Neonatal Conditions: The licensed midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions exist.

a. Apgar score of 6 or less at five minutes of age, without significant improvement by 10 minutes
b. persistent respiratory distress
c. persistent cardiac irregularities
d. persistent central cyanosis or pallor
e. persistent lethargy or poor muscle tone
f. prolonged temperature instability
g. significant signs or symptoms of infection
h. significant clinical evidence of glycemic instability
i. seizures
j. abnormal bulging or depressed fontanel
k. birth weight <2300 grams
l. significant clinical evidence of prematurity
m. clinically significant jaundice apparent at birth
n. major or medically significant congenital anomalies
o. significant or suspected birth injury
p. other serious medical conditions
q. parental request

B. Postnatal Care: The licensed midwife will arrange for consultation, referral or transport for an infant who exhibits the following:

a. abnormal cry
b. diminished consciousness
c. inability to suck

d. passes no urine in 30 hours or meconium in 48 hours after delivery or inadequate production of urine or stool during the neonatal period
e. clinically significant abnormalities in vital signs, muscle tone or behavior
f. clinically significant color abnormality - cyanotic, pale, grey
g. abdominal distension, projectile vomiting
h. jaundice within 30 hours of birth
i. significant signs or symptoms of infection
j. abnormal lab results
k. signs of clinically significant dehydration or failure to thrive
l. other concerns of family or licensed midwife

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT **YEAR** _____

This report is due on or before March 31 in the year following the year of reporting.

First Name	Last Name	
Address		
City	State	ZIP Code

License Number LM - _____

1 Did you, or a student midwife supervised by you, perform midwife services during the year when the intended place of birth at the onset of care was an out-of-hospital setting? Yes____ No____

If you answered no, skip items 2 - 13, sign and date the report, and mail it to OSHPD at the address provided in the instructions.

2 Total number of clients served as primary caregiver at the onset of care _____

3 Total number of clients served with collaborative care available through, or given by, a licensed physician and surgeon _____

4 Total number of clients served under supervision of a licensed physician and surgeon _____

5 Number of live births attended as the primary caregiver by county
(If additional space is needed use a separate Supplemental Reporting Form and reference this item number

County Code	Number	County Code	Number

6 Number of cases of fetal demise attended as primary caregiver at the discovery of the demise by county
(If additional space is needed use a separate Supplemental Reporting Form and reference this item numbe

County Code	Number	County Code	Number

DRAFT as of 3/9/07

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT **YEAR** _____

First Name	Last Name	License Number LM -

7 Number of women whose primary care was transferred to another care practitioner during the antepartum period, and the reason for each transfer
(If additional space is needed use a separate Supplemental Reporting Form and reference this item number)

Reason Code	Number	Reason Code	Number

8 Number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period
(If additional space is needed use a separate Supplemental Reporting Form and reference this item number)

Reason Code	Number	Outcome Code	Number
r)			

9 Number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period
(If additional space is needed use a separate Supplemental Reporting Form and reference this item number)

Reason Code	Number	Outcome Code	Number

10 Number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period
(If additional space is needed use a separate Supplemental Reporting Form and reference this item number)

Reason Code	Number	Outcome Code	Number

DRAFT as of 3/9/07

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT **YEAR** _____

First Name Last Name

License Number LM - _____

11 a Number of planned out-of-hospital births at the onset of labor _____

11 b Number of births completed in an out-of-hospital setting _____

12 Number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:

a Twin births _____

b Multiple births other than twin births _____

c Breech births _____

d Vaginal births after the performance of a caesarian section (VBAC) _____

13 Did the result of service to any client or infant result in the mortality of the mother or infant? Yes___ No___

If you answered no, skip this item sign and date the report, and mail it to OSHPD at the address provided in the instructions.

If you answered yes, enter the number of mother and/or infant fatalities below:

Mother fatalities _____ Infant fatalities _____

Provide a brief description of any complications resulting in the mortality of a mother or an infant
(If additional space is needed attach additional pages as needed and reference this item number)

1 _____

2 _____

3 _____

4 _____

(DESIGN NOTE: OR A CODING METHOD OF REPORTING COMPLICATIONS COULD BE USED)

Complication Code	Number	Complication Code	Number

Signature _____ Date _____

DRAFT as of 3/9/07

Supplemental Reporting Form County Code Form

Item 5 - Report any additional county amounts here that were not already reported on page 1.

Number of live births attended as the primary caregiver by county.

County Code	County Name	Number	County Code	County Name	Number	County Code	County Name	Number
1	Alameda		21	Marin		40	San Luis Obispo	
2	Alpine		22	Mariposa		41	San Mateo	
3	Amador		23	Mendocino		42	Santa Barbara	
4	Butte		24	Merced		43	Santa Clara	
5	Calaveras		25	Modoc		44	Santa Cruz	
6	Colusa		26	Mono		45	Shasta	
7	Contra Costa		27	Monterey		46	Sierra	
8	Del Norte		28	Napa		47	Siskiyou	
9	El Dorado		29	Nevada		48	Solano	
10	Fresno		30	Orange		49	Sonoma	
11	Glenn		31	Placer		50	Stanislaus	
12	Humbolt		32	Plumas		51	Sutter	
13	Imperial		33	Riverside		52	Tehama	
14	Inyo		34	Sacramento		53	Trinity	
15	Kern		35	San Benito		54	Tuolumne	
16	Kings		36	San Bernardino		55	Tulare	
17	Lake		37	San Diego		56	Ventura	
18	Lassen		38	San Francisco		57	Yolo	
19	Los Angeles		39	San Joaquin		58	Yuba	
20	Madera							

Item 6 - Report any additional county amounts here that were not already reported on page 1.

Number of cases of fetal demise attended as primary caregiver at the discovery of the demise by county.

County Code	County Name	Number	County Code	County Name	Number	County Code	County Name	Number
1	Alameda		21	Marin		40	San Luis Obispo	
2	Alpine		22	Mariposa		41	San Mateo	
3	Amador		23	Mendocino		42	Santa Barbara	
4	Butte		24	Merced		43	Santa Clara	
5	Calaveras		25	Modoc		44	Santa Cruz	
6	Colusa		26	Mono		45	Shasta	
7	Contra Costa		27	Monterey		46	Sierra	
8	Del Norte		28	Napa		47	Siskiyou	
9	El Dorado		29	Nevada		48	Solano	
10	Fresno		30	Orange		49	Sonoma	
11	Glenn		31	Placer		50	Stanislaus	
12	Humbolt		32	Plumas		51	Sutter	
13	Imperial		33	Riverside		52	Tehama	
14	Inyo		34	Sacramento		53	Trinity	
15	Kern		35	San Benito		54	Tuolumne	
16	Kings		36	San Bernardino		55	Tulare	
17	Lake		37	San Diego		56	Ventura	
18	Lassen		38	San Francisco		57	Yolo	
19	Los Angeles		39	San Joaquin		58	Yuba	
20	Madera							

DRAFT as of 3/9/07

DRAFT as of 3/9/07

Supplemental Reporting Form
for Item Number _____

Refer to the reason code table included in the instructions that provides direction in completing the California Licensed Midwife Annual Report.

Reason Code	Number

Reason Code	Number

Reason Code	Number

DRAFT as of 3/9/07

DRAFT as of 3/9/07

Supplemental Reporting Form
for Item Number ________

Refer to the reason and outcome code tables included in the instructions that provides direction in completing the California Licensed Midwife Annual Report.

Reason Code	Number
Total	

Outcome Code	Number
Total	

DRAFT as of 3/9/07

Agenda Item 3

State of California **Department of Consumer Affairs**
Medical Board of California

M e m o r an n d u m

To: Members, Midwifery Advisory Council **Date**: March 27, 2007

From: Kathi Burns
Manager, Licensing Operations Section

Subject: Schedule of Future Meetings

The current schedule of Midwifery Advisory Council Meetings (MAC) is as follows. It is recommended that since a MAC meeting is to be held on April 17, 2007, that the May meeting be moved to June 14, 2007.

SCHEDULED	PROPOSED
Thursday, May 24, 2007	Thursday, June 14, 2007
Thursday, August 30, 2007	Remain unchanged
Thursday, December 6, 2007	Remain unchanged

Schedule of Medical Board of California Meetings:

April 26-27, 2007
July 26-27, 2007
November 1-2, 2007